Susan M. Collins

TAM18383 S.L.C.

AMENDMENT NO._____ Calendar No._____

Purpose: To stabilize individual market premiums and provide meaningful State flexibility.

IN THE SENATE OF THE UNITED STATES—115th Cong., 2d Sess.

H.R. 1625

To a **AMENDMENT No. 2216** ct of
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By Collins

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Viz:

In division H, after section 229, insert the following:

SEC. 230. WAIVERS FOR STATE INNOVATION; COST-SHARING PAYMENTS.

(a) WAIVERS FOR STATE INNOVATION.—

(1) STREAMLINING THE STATE APPLICATION PROCESS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(A) in subsection (a)(1)(C), by striking "the law" and inserting "a law or has in effect a certification"; and

(B) in subsection (b)(2)—

(i) in the paragraph heading, by inserting "OR CERTIFY" after "LAW";

(ii) in subparagraph (A)—

(I) by striking "A law" and inserting the following:

"(i) LAWS.—A law"; and

(II) by adding at the end the following:

"(ii) CERTIFICATIONS.—A certification described in this paragraph is a document, signed by the Governor of the State, that certifies that such Governor has the authority under existing Federal and State law to take action under this section, including implementation of the State plan under subsection (a)(1)(B).";

and

(iii) in subparagraph (B)—

(I) in the subparagraph heading, by striking "OF OPT OUT"; and

(II) by striking "may repeal a law" and all that follows through the period at the end and inserting the following: "may terminate the authority provided under the waiver with respect to the State by—

"(i) repealing a law described in subparagraph (A)(i); or

"(ii) terminating a certification described in subparagraph (A)(ii), through a certification for such termination signed by the Governor of the State.".

(2) GIVING STATES MORE FUNDING FLEXIBILITY, TO ESTABLISH REINSURANCE, INVISIBLE HIGH RISK POOLS, INSURANCE STABILITY FUNDS AND OTHER PROGRAMS.—

(A) STATE GRANTS UNDER WAIVERS.—Section 1332(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(a)) is amended—

(i) in paragraph (3)—

(I) in the first sentence—

(aa) by inserting "or would qualify for a reduced portion of" after "would not qualify for";

(bb) by inserting ", or the State would not qualify for or would qualify for a reduced portion of basic health program funds under section 1331," after "subtitle E";

(cc) by inserting ", or basic health program funds the State would have received," after "this title"; and

(dd) by inserting "or for implementing the basic health program established under section 1331" before the period;

(II) in the second sentence, by inserting before the period ", and with respect to participation in the basic health program and funds provided to such other States under section 1331"; and

(III) by adding after the second sentence the following: "A State may request that all of, or any portion of, such aggregate amount of such credits, reductions, or funds be paid to the

State as described in the first sentence.";

(ii) by redesignating paragraphs (4), (5), and (6) as paragraphs (5), (6), and (7), respectively; and

(iii) by inserting after paragraph (3) the following:

"(4) FEDERAL FUNDING FOR INVISIBLE HIGH-RISK POOL AND REINSURANCE PROGRAMS.—

"(A) ALLOCATIONS.—Not later than 45 days after the date of enactment of the Department of Health and Human Services Appropriations Act, 2018, the Secretary, in consultation with the National Association of Insurance Commissioners, shall specify an allocation methodology for determining the amount of funds appropriated under section 230(a)(2)(B) of the Department of Health and Human Services Appropriations Act, 2018 for a fiscal year to be allocated for each State for purposes of subparagraph (B) and section 230(a)(2)(C) of the Department of Health and Human Services Appropriations Act, 2018.

"(B) STATE GRANTS.—From amounts appropriated under section 230(a)(2)(B) of the

Department of Health and Human Services Appropriations Act, 2018 for a fiscal year, the Secretary shall award grants to States for each of fiscal years 2018 through 2021, in amounts determined in accordance with the allocation methodology under subparagraph (A), for the following purposes:

"(i) For fiscal year 2018, for administrative costs of the State associated with preparing and submitting information described in subsection (a)(1)(B) that includes an invisible high-risk pool or reinsurance program that meets the requirements of subsection (g)(2), or costs associated with the establishment of such invisible high-risk pool or reinsurance program.

"(ii) For each of fiscal years 2019, 2020, and 2021, for the establishment or maintenance of invisible high-risk pools and reinsurance programs that meet the requirements of subsection (g)(2) and for which the State has received a waiver under this section.

"(C) BUDGET NEUTRALITY.—Funds awarded to a State under a grant awarded

under subparagraph (B) shall not be taken into account for purposes of determining under paragraph (1) whether the State waiver is budget neutral, or determining under subsection (b)(1) whether the State waiver increases the Federal deficit.".

(B) APPROPRIATIONS.—

(i) IN GENERAL.—There are authorized to be appropriated, and there are appropriated, to the Secretary of Health and Human Services, for the purposes described in section 1332(a)(4)(B) of the Patient Protection and Affordable Care Act and subparagraph (C), out of any funds in the Treasury not otherwise appropriated—

(I) $500,000,000 for fiscal year 2018; and

(II) $10,000,000,000 for each of fiscal years 2019, 2020, and 2021.

(ii) AVAILABLE UNTIL EXPENDED.—Amounts appropriated under this paragraph shall remain available until expended.

(C) DEFAULT FEDERAL SAFEGUARD.—

(i) IN GENERAL.—For purposes of plan year 2019, in the case of a State that does not, by a date specified by the Secretary of Health and Human Services (referred to in this paragraph as the "Secretary"), in consultation with the National Association of Insurance Commissioners, have in effect a waiver under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) that includes an invisible high-risk pool or reinsurance program that meets the requirements of subsection (g)(2) of such section 1332, the Secretary shall, from amounts appropriated under subparagraph (B), use the allocation determined for the State under subsection (a)(4)(B) of such section 1332 for plan year 2019 for the purpose described in clause (ii) for such State.

(ii) REQUIRED USE FOR MARKET STABILIZATION PAYMENTS TO ISSUERS.—The Secretary shall use any allocation for a State made pursuant to clause (i) to provide incentives to appropriate entities to enter into arrangements with the State to

help stabilize premiums for health insurance coverage in the individual market in such State by providing payments to such appropriate entities using payment parameters and a methodology determined by the Secretary.

(3) ENSURING PATIENT ACCESS TO MORE FLEXIBLE HEALTH PLANS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(A) in subsection (b)—

(i) in paragraph (1)—

(I) in subparagraph (B), by striking "at least as affordable" and inserting "of comparable affordability, including for low-income individuals, individuals with serious health needs, and other vulnerable populations,"; and

(II) by amending subparagraph (D) to read as follows:

"(D)(i) will not increase the Federal deficit over the term of the waiver; and

"(ii) will not increase the Federal deficit over the term of the 10-year budget plan submitted under subsection (a)(1)(B)(ii).";

(ii) by redesignating paragraph (2) (as amended by paragraph (1)) as paragraph (3); and

(iii) by inserting after paragraph (1) the following:

"(2) BUDGETARY EFFECT.—

"(A) IN GENERAL.—In determining whether a State plan submitted under subsection (a) meets the deficit neutrality requirements of paragraph (1)(D), the Secretary may take into consideration the direct budgetary effect of the provisions of such plan on sources of Federal funding other than the funding described in subsection (a)(3).

"(B) LIMITATION.—A determination made by the Secretary under subparagraph (A)—

"(i) shall not be construed to affect any waiver process or standards or terms and conditions in effect on the date of enactment of the Department of Health and Human Services Appropriations Act, 2018 under title XI, XVIII, XIX, or XXI of the

Social Security Act, or any other Federal law relating to the provision of health care items or services; and

"(ii) shall be made without regard to any changes in policy with respect to any waiver process or provision of health care items or services described in clause (i).";

and

(B) in subsection (a)(1)(C), by striking "subsection (b)(2)" and inserting "subsection (b)(3)".

(4) PROVIDING EXPEDITED APPROVAL OF STATE WAIVERS.—Section 1332(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(d)) is amended—

(A) in paragraph (1) by striking "180" and inserting "120"; and

(B) by adding at the end the following:

"(3) EXPEDITED DETERMINATION.—

"(A) IN GENERAL.—With respect to any application under subsection (a)(1) submitted on or after the date of enactment of the Department of Health and Human Services Appropriations Act, 2018 or any such application submitted prior to such date of enactment and

under review by the Secretary on such date of enactment, the Secretary shall make a determination on such application, using the criteria for approval otherwise applicable under this section, not later than 45 days after the receipt of such application, and shall allow the public notice and comment at the State and Federal levels described under subsection (a)(5) to occur concurrently if such State application—

"(i) is submitted in response to an urgent situation, with respect to areas in the State that the Secretary determines are at risk for excessive premium increases or having no health plans offered in the applicable health insurance market for the current or following plan year;

"(ii) is for a waiver that is the same or substantially similar to a waiver that the Secretary already has approved for another State; or

"(iii) is for a waiver that includes an invisible high-risk pool or reinsurance program described in subparagraph (A), (B), or (D) of subsection (g)(2).

"(B) APPROVAL.—

"(i) URGENT SITUATIONS.—

"(I) PROVISIONAL APPROVAL.—A waiver approved under the expedited determination process under subparagraph (A)(i) shall be in effect for a period of 3 years, unless the State requests a shorter duration.

"(II) FULL APPROVAL.—Subject to the requirements for approval otherwise applicable under this section, not later than 1 year before the expiration of a provisional waiver period described in subclause (I) with respect to an application described in subparagraph (A)(i), the Secretary shall make a determination on whether to extend the approval of such waiver for the full term of the waiver requested by the State, for a total approval period not to exceed 6 years. The Secretary may request additional information as the Secretary determines appropriate to make such determination.

"(ii) APPROVAL OF SAME OR SIMILAR APPLICATIONS.—An approval of a waiver under subparagraph (A)(ii) shall be subject to the terms of subsection (c).

"(C) GAO STUDY.—Not later than 5 years after the date of enactment of the Department of Health and Human Services Appropriations Act, 2018, the Comptroller General of the United States shall conduct a review of all waivers approved pursuant to subparagraph (A)(ii) to evaluate whether such waivers met the requirements of subsection (b)(1) and whether the applications should have qualified for such expedited process.".

(5) PROVIDING CERTAINTY FOR STATE-BASED REFORMS.—Section 1332(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(c)) is amended by striking "No waiver" and all that follows through the period at the end and inserting the following: "A waiver under this section—

"(1) shall be in effect for a period of 6 years unless the State requests a shorter duration;

"(2) may be renewed, subject to the State meeting the criteria for approval otherwise applicable

under this section, for unlimited additional 6-year periods upon application by the State; and

"(3) may not be suspended or terminated, in whole or in part, by the Secretary at any time before the date of expiration of the waiver period (including any renewal period under paragraph (2)), unless the Secretary determines that the State materially failed to comply with the terms and conditions of the waiver.".

(6) GUIDANCE AND REGULATIONS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(A) by adding at the end the following:

"(f) GUIDANCE AND REGULATIONS.—

"(1) IN GENERAL.—With respect to carrying out this section, the Secretary shall—

"(A) issue guidance, not later than 60 days after the date of enactment of the Department of Health and Human Services Appropriations Act, 2018, that includes initial examples of model State plans that meet the requirements for approval under this section; and

"(B) periodically review the guidance issued under subparagraph (A) and when appropriate, issue additional examples of model

State plans that meet the requirements for approval under this section, which may include—

"(i) State plans establishing reinsurance or invisible high-risk pool arrangements for purposes of covering the cost of high-risk individuals;

"(ii) State plans expanding insurer participation, access to affordable health plans, network adequacy, and health plan options over the entire applicable health insurance market in the State;

"(iii) waivers encouraging or requiring health plans in such State to deploy value-based insurance designs which structure enrollee cost-sharing and other health plan design elements to encourage enrollees to consume high-value clinical services;

"(iv) State plans allowing for significant variation in health plan benefit design; or

"(v) any other State plan as the Secretary determines appropriate.

"(2) RESCISSION OF PREVIOUS REGULATIONS AND GUIDANCE.—Beginning on the date of enactment of the Department of Health and Human

Services Appropriations Act, 2018, the regulations promulgated, and the guidance issued, under this section prior to the date of enactment of the Department of Health and Human Services Appropriations Act, 2018 shall have no force or effect."; and

(B) in subsection (a)(5) (as redesignated by paragraph (2)(A)(ii))—

(i) in subparagraph (A), by inserting ", as applicable" before the period; and

(ii) in subparagraph (B), by striking "Not later than 180 days after the date of enactment of this Act, the Secretary shall" and inserting "The Secretary may".

(7) INVISIBLE HIGH RISK POOLS AND REINSURANCE PROGRAMS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052), as amended by paragraph (6), is further amended by adding at the end the following:

"(g) INVISIBLE HIGH RISK POOLS AND REINSURANCE PROGRAMS.—

"(1) FUNDING.—With respect to a State that has received a waiver under this section to establish an invisible high-risk pool or reinsurance program described in paragraph (2), the State may fund such

program, in whole or in part, using one or both of the following:

"(A) Amounts received through a grant described in subsection (a)(4)(B).

"(B) All of, or a portion of, the payments made to the State as described in subsection (a)(3), consistent with the information the State provides under subsection (a)(1)(B).

"(2) PROGRAM DESIGN.—An invisible high-risk pool or reinsurance program described in this paragraph is a program that meets any of the following:

"(A) An invisible high-risk pool, as defined by the State, under which health insurance issuers, with respect to designated individuals who experience higher than average health costs as determined by the State, and are enrolled in health insurance coverage offered in the individual market, cede risk to the pool, without affecting the premium paid by the designated individuals or their terms of coverage. With respect to such pool, the State, or an entity operating the pool on behalf of the State, shall establish—

"(i) the premium amount the ceding issuer shall pay to the reinsurance pool;

"(ii) the applicable attachment points or coinsurance percentages if the ceding issuer retains any portion of the risk under ceded policies; and

"(iii) the mechanism by which high-risk individuals are designated for cession to the pool, which may include a list of designated high-cost health conditions.

"(B) A reinsurance program, as defined by the State, that assumes a portion of the risk for individuals who experience higher than average health costs as determined by the State, in a manner substantially similar to the reinsurance program that operated in the State in accordance with section 1341.

"(C) A reinsurance program established by the State not otherwise described in this paragraph.

"(D) A program based on another State's reinsurance program—

"(i) described in subparagraph (A), (B), or (C), for which an application has been approved under this subsection; or

"(ii) which was implemented prior to September 1, 2017, and which the Sec-

retary determines meets the requirements of subparagraph (A).".

(8) APPLICABILITY.—The amendments made by this Act to section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052)—

(A) with respect to applications for waivers under such section 1332 submitted after the date of enactment of this Act and applications for such waivers submitted prior to such date of enactment and under review by the Secretary on the date of enactment, shall take effect on the date of enactment of this Act; and

(B) with respect to applications for waivers approved under such section 1332 before the date of enactment of this Act, shall not require reconsideration of whether such applications meet the requirements of such section 1332, except that, at the request of a State, the Secretary shall recalculate the amount of funding provided under subsection (a)(3) of such section.

(9) CLARIFYING BUDGET NEUTRALITY.—Section 1332(a)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(a)(1)(B)) is amended—

(A) in clause (i), by inserting ", including, as applicable, a description of the State's plan to use any amounts awarded to the State under paragraph (4) to support an invisible high-risk pool or reinsurance program consistent with subsection (g) and such information about such program as the Secretary may require" before the semicolon; and

(B) in clause (ii), by inserting "over both the term of the proposed waiver and the term of the 10-year budget plan" after "Government".

(b) COST-SHARING PAYMENTS.—

(1) IN GENERAL.—There is appropriated to the Secretary of Health and Human Services (referred to in this section as the "Secretary"), out of any funds in the Treasury not otherwise obligated, such sums as may be necessary for payments for cost-sharing reductions, as authorized by section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) for the portion of plan year 2017 that begins on October 1, 2017, and ends on December 31, 2017, and for plan years 2019, 2020, and 2021.

(2) SPECIAL RULES FOR COST-SHARING REDUCTIONS.—

(A) BASIC HEALTH PLAN.—For plan year 2018, there is appropriated to the Secretary, out of any funds in the Treasury not otherwise obligated, such sums as may be necessary for, with respect to States that have in effect a basic health plan on January 1, 2018, the portion of transfers pursuant to section 1331(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18051(d)) attributable to the cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) that would have been provided for plan year 2018 with respect to eligible individuals enrolled in standard health plans in such States.

(B) HOLD HARMLESS.—

(i) IN GENERAL.—For plan year 2018, there is appropriated to the Secretary, out of any funds in the Treasury not otherwise obligated, such sums as may be necessary for payments for cost-sharing reductions authorized by section 1402 of the Patient Protection and Affordable Care

Act (42 U.S.C. 18071) with respect to qualified health plans described in clause (ii).

(ii) QUALIFIED HEALTH PLANS DESCRIBED.—A qualified health plan described in this clause is a qualified health plan for which the Secretary determines, based on a certification and appropriate documentation from the issuer of such plan and a certification from the applicable State regulator, that the health insurance issuer of such plan has not increased premium rates for plan year 2018 on account of the issuer assuming, or being instructed by applicable State regulators to assume, that the issuer would receive payments under such section 1402.

(C) CLARIFICATION OF OBLIGATIONS.—

(i) NO REQUIREMENTS TO MAKE PAYMENTS.—Notwithstanding any other provision of law, there shall be no obligation under this Act or any other Act, including the Patient Protection and Affordable Care Act (Public Law 111-148), to make payments for cost-sharing reductions under

section 1402(c)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(c)(3)) or advance payments for such cost-sharing reductions under section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) for plan year 2018, except for such payments for which amounts are appropriated under subparagraphs (A) and (B). Nothing in this clause shall be construed as affecting the requirements under section 1402 of the Patient Protection and Affordable Care Act for issuers to reduce cost-sharing.

(ii) NO OBLIGATION TO RECONCILE PAYMENTS.—Notwithstanding any other provision of law, there shall be no obligation under this Act or any other Act, including the Patient Protection and Affordable Care Act (Public Law 111-148), to make payments on or after October 1, 2017, for the purpose of reconciling any cost-sharing reduction payments by the Secretary under section 1402(c)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(c)(3)) made for plan

year 2016 or the plan year beginning January 1, 2017, through September 30, 2017.

(D) TREATMENT OF PREVIOUS PAYMENTS.—Notwithstanding any other provision of law, payments made for cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) during the period beginning on January 1, 2014, and ending on September 30, 2017, shall be treated in the same manner as a refund due from the credit allowed under section 36B of the Internal Revenue Code of 1986 for the purposes of section 1324 of title 31, United States Code.

(c) HEALTH BENEFITS COVERAGE.—Notwithstanding any other provision of law, including any other definition of "health benefits coverage" for purposes of subsection (b) and (c) of section 506, any use made of funds appropriated under subsection (b) starting in plan year 2019, and subsection (a)(2)(B) starting in plan year 2018, and any program, activity, plan, or coverage funded or supported by such funds, shall constitute "health benefits coverage".

(d) LIMITATIONS.—The following shall apply:

(1) Nothing in this section shall be construed to limit the applicability of subsection (a), (b), or (d) of section 507.

(2) For purposes of this section, a health insurance issuer expending State, local, or private funds, shall be treated in the same manner as a managed care provider described in section 507(c).

SEC. 231. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM COPPER PLAN.

(a) IN GENERAL.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended—

(1) in paragraph (1)—

(A) by redesignating clauses (i) and (ii) of subparagraph (B) as subparagraphs (A) and (B), respectively, and adjusting the margins accordingly;

(B) by striking "plan year if—" and all that follows through "the plan provides—" and inserting "plan year if the plan provides—"; and

(C) in subparagraph (A), as redesignated by paragraph (1), by striking "clause (ii)" and inserting "subparagraph (B)";

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) RISK POOLS.—Section 1312(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)) is amended by inserting "and including enrollees in catastrophic plans described in section 1302(e)" after "Exchange".

(c) CONFORMING AMENDMENT.—Section 1312(d)(3)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(d)(3)(C)) is amended by striking ", except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2)".

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall apply with respect to plan years beginning on or after January 1, 2019.

SEC. 232. CONSUMER OUTREACH, EDUCATION, AND ASSISTANCE.

(a) OPEN ENROLLMENT REPORTS.—For plan years 2019 and 2020, the Secretary of Health and Human Serv-

ices (referred to in this section as the "Secretary"), in coordination with the Secretary of the Treasury and the Secretary of Labor, shall issue biweekly public reports during the annual open enrollment period on the performance of the Federal Exchange and the Small Business Health Options Program (SHOP) Marketplace. Each such report shall include a summary, including information on a State-by-State basis where available, of—

(1) the number of unique website visits;

(2) the number of individuals who create an account;

(3) the number of calls to the call center;

(4) the average wait time for callers contacting the call center;

(5) the number of individuals who enroll in a qualified health plan; and

(6) the percentage of individuals who enroll in a qualified health plan through each of—

(A) the website;

(B) the call center;

(C) navigators;

(D) agents and brokers;

(E) the enrollment assistant program;

(F) directly from issuers or web brokers; and

(G) other means.

(b) OPEN ENROLLMENT AFTER ACTION REPORT.—For plan years 2019 and 2020, the Secretary, in coordination with the Secretary of the Treasury and the Secretary of Labor, shall publish an after action report not later than 3 months after the completion of the annual open enrollment period regarding the performance of the Federal Exchange and the Small Business Health Options Program (SHOP) Marketplace for the applicable plan year. Each such report shall include a summary, including information on a State-by-State basis where available, of—

(1) the open enrollment data reported under subsection (a) for the entirety of the enrollment period; and

(2) activities related to patient navigators described in section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)), including—

(A) the performance objectives established by the Secretary for such patient navigators;

(B) the number of consumers enrolled by such a patient navigator;

(C) an assessment of how such patient navigators have met established performance

metrics, including a detailed list of all patient navigators, funding received by patient navigators, and whether established performance objectives of patient navigators were met; and

(D) with respect to the performance objectives described in subparagraph (A)—

(i) whether such objectives assess the full scope of patient navigator responsibilities, including general education, plan selection, and determination of eligibility for tax credits, cost-sharing reductions, or other coverage;

(ii) how the Secretary worked with patient navigators to establish such objectives; and

(iii) how the Secretary adjusted such objectives for case complexity and other contextual factors.

(c) REPORT ON ADVERTISING AND CONSUMER OUTREACH.—Not later than 3 months after the completion of the annual open enrollment period for the 2019 plan year, the Secretary shall issue a report on advertising and outreach to consumers for the open enrollment period for the 2019 plan year. Such report shall include a description of—

(1) the division of spending on individual advertising platforms, including television and radio advertisements and digital media, to raise consumer awareness of open enrollment;

(2) the division of spending on individual outreach platforms, including email and text messages, to raise consumer awareness of open enrollment; and

(3) whether the Secretary conducted targeted outreach to specific demographic groups and geographic areas.

(d) OUTREACH AND ENROLLMENT ACTIVITIES.—

(1) OPEN ENROLLMENT.—Of the amounts collected through the user fees on participating health insurance issuers pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations), the Secretary shall obligate $105,800,000 for outreach and enrollment activities for each of the open enrollment periods for plan years 2019 and 2020.

(2) OUTREACH AND ENROLLMENT ACTIVITIES.—

(A) IN GENERAL.—For purposes of this subsection, the term "outreach and enrollment activities" means—

(i) activities to educate consumers about coverage options or to encourage consumers to enroll in or maintain health insurance coverage (excluding allocations to the call center for the Federal Exchange); and

(ii) activities conducted by an in-person consumer assistance program that does not have a conflict of interest and that, among other activities, facilitates enrollment of individuals through the Federal Exchange, and distributes fair and impartial information concerning enrollment through such Exchange and the availability of tax credits and cost-sharing reductions.

(B) CONNECTION WITH FEDERAL EXCHANGE.—Activities conducted under this subsection shall be in connection with the operation of the Federal Exchange, to provide special benefits to health insurance issuers participating in the Federal Exchange.

(3) CONTRACT AUTHORITY.—The Secretary may contract with a State to conduct outreach and enrollment activities for plan years 2019 and 2020. Any outreach and enrollment activities conducted by

a State or other entity at the direction of the State, in accordance with such a contract, shall be treated as Federal activities to provide special benefits to participating health insurance issuers consistent with OMB Circular No. A–25R.

(4) CLARIFICATIONS.—

(A) PRIOR FUNDING.—Nothing in this subsection should be construed as rescinding or cancelling any funds already obligated on the date of enactment of this Act for outreach and enrollment activities for plan year 2019.

(B) AVAILABILITY OF FUNDING.—The Secretary shall ensure that outreach and enrollment activities are conducted in all applicable States, including, as necessary, by providing for such activities through contracts described in paragraph (3).

SEC. 233. OFFERING HEALTH PLANS IN MORE THAN ONE STATE.

Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the National Association of Insurance Commissioners, shall issue regulations for the implementation of health care choice compacts established under section 1333 of the Patient Protection and Affordable

Care Act (42 U.S.C. 18053) to allow for the offering of health plans in more than one State.

SEC. 234. CONSUMER NOTIFICATION.

In addition to any applicable Federal requirements with respect to short-term limited duration insurance, a State insurance commissioner shall require the issuer of short-term, limited duration insurance approved for sale in the State to display prominently in marketing materials, the contract, and application materials provided in connection with enrollment in such insurance a notice to consumers that includes such information as the State insurance commissioner determines sufficient to inform the individual that coverage and benefits under such insurance differ from coverage and benefits under qualified health plans.